Personal Training Registration Packet
PERSONAL TRAINING INTRODUCTION AND POLICIES

A Message from the Assistant Director for Fitness/Wellness
Campus Recreation is pleased that you are interested in training with us. Our goal is to educate our clients to exercise safely and effectively for life. Our trainers will work with you to develop a fitness program based on your goals and fitness level. We will closely supervise and assess your progress. Along the way, we’ll provide you with the knowledge, guidance and resources you need to become comfortable and confident in any fitness environment.

This packet includes information on client/trainer expectations, your health and exercise history, and fitness goals. The packet should be completed in its entirety and returned to Member Services with your package selection and payment. The information in this packet will help your personal trainer develop a customized program for you; therefore, it is important that you answer all questions honestly. Information is kept confidential. The following forms must be signed and submitted to the Assistant Director for Fitness/Wellness before your program begins:
- Personal Training Registration & Waiver
- PAR-Q
- Health History Questionnaire
- Exercise History and Goals
- Personal Training Client/Trainer Agreement

You may keep this page (introduction & policies), the Personal Training Fitness Assessment description page, and a copy of the client/trainer agreement.

Sincerely,
Jill M. Isabelle
Jill Isabelle
Assistant Director Fitness/Wellness
(413) 577-0855
jisabelle@admin.umass.edu

PERSONAL TRAINING POLICIES
- Personal training clients MUST complete and submit all required forms with the registration fee prior to scheduling the first session.
- If you check ‘Yes’ to any questions on the PAR-Q questionnaire, you must also return a Medical Release Form (completed by your physician) prior to beginning training sessions.
- The Assistant Director will assign a trainer to each client based on compatibility of client goals and trainer expertise. A participant can request a specific trainer on the PT registration form. See website for trainer biographies and availability
- For new clients, your FIRST session will consist of a Fitness Assessment
- Returning clients do not need to complete an additional fitness assessment but may choose to do so if interested.
- The personal trainer and the client will agree to complete the sessions purchased. Sessions will be scheduled at mutually convenient, agreed upon times.
- If mutually convenient times are unavailable, the client must contact the Assistant Director of Fitness Wellness for reassignment
- If the client is unable to make a scheduled session, the client must notify the personal trainer at least 24 hours in advance. Failure to do so will result in the client forfeiting the session and no payment reimbursement will be granted.
- Campus Recreation allows a 15-minute grace period for late arrival to a scheduled session. The personal trainer will only wait 15 minutes past the scheduled meeting time, unless the participant has alerted the trainer of the expected tardiness. The personal trainer may or may not be able to extend the training session to make up the 15 minutes.
- Personal training packages should be used in full within the semester of purchase.
- If unused sessions remain at the conclusion of the semester, these sessions may roll over and be used ONLY in the following semester at the discretion of the Assistant Director of Fitness/Wellness.
PERSONAL TRAINING PACKAGES

PERSONAL TRAINING REGISTRATION AND FEES
- Participants must include payment when submitting the registration forms to Member Services.
- Personal Training sessions must be used within the semester in which they were purchased. Full refunds are not available once the sessions have begun. Sessions are non-transferable.

<table>
<thead>
<tr>
<th>Packages/Sessions</th>
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<tr>
<td>2 sessions</td>
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<td>4 sessions</td>
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<td>6 sessions</td>
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<td>10 sessions</td>
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<tr>
<td>Fitness Assessment</td>
<td>$15</td>
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<tr>
<td>Body Composition</td>
<td>$10</td>
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The **Intro Session** (approximately one hour) includes meeting your personal trainer, discussing your workout goals, completing a fitness assessment, having an equipment orientation and completing any necessary paperwork. The following are included in your Intro Session:

1) **Fitness Assessments** are an important part of every exercise program and are an excellent way to gauge your current fitness level. A fitness assessment measures height, weight, body composition, blood pressure, flexibility, muscular endurance and cardiovascular endurance.

2) **Body Composition** measures lean body mass to fat body mass using a skin fold caliper.

**Our Trainers** have earned their personal training certification through one of the following nationally-recognized organizations: American Council on Exercise (ACE), Aerobic and Fitness Association of America (AFAA), National Strength and Conditioning Association (NSCA), American College of Sports Medicine (ACSM), or International Fitness Professionals Association (IFPA). In addition to the certifications and our in-house training, our personal trainers are required to complete continuing education requirements to maintain their certifications and to keep current with the latest fitness research and trends.
The fitness assessment is a helpful tool to determine a client’s current fitness level. A fitness assessment is a series of tests in a relaxed, individualized setting that will identify the client’s strengths and weaknesses so that the trainer and client will best be able to develop fitness plans.

What you should know and how to prepare:

- Wear proper fitting athletic clothing and shoes.
- Drink plenty of fluids over the 24-hour period preceding the test to ensure normal hydration prior to the testing.
- Avoid heavy meals, tobacco, alcohol, and caffeine for at least 3 hours before testing. It is helpful to have a small snack 30 minutes to 1 hour before the test.
- Avoid heavy exercise or strenuous physical activity the day of the test.
- Try to get an adequate amount of sleep (6-8 hours) the night before the test.

A Fitness Assessment measures height, weight, body composition, blood pressure, muscular endurance, cardiovascular endurance, functional movement and flexibility. The specific tests that you will be asked to perform are:

1. Cardiovascular endurance test – some form of endurance exercise determined by client and trainer
2. Push-up test
3. Forearm plank
4. Forward fold
5. Thomas Test (hip flexion) - The Thomas Test is a quick, simple assessment used to examine the length of the three critical muscles of the hip involved in hip flexion.
6. Overhead squat - The overhead squat test is used to assess dynamic flexibility, core strength, balance and overall neuromuscular control.
7. Scapular wall slides - The scapula slide test determines healthy shoulder function which requires a balance of scapular stability, arm flexibility, and good motor control during arm movement.
PERSONAL TRAINING REGISTRATION & WAIVER

Today's Date _______/_______/______
   (Month)  (Day)   (Year)

Personal Training Package: (all packages INCLUDE intro session/fit assessment and body comp)

☐ 2 Sessions $50  ☐ 4 Sessions $90
☐ 6 Sessions $120  ☐ 10 Sessions $180
☐ Fitness Assessment $15  ☐ Body Composition $10

Fitness Goals:

☐ Improve cardiovascular fitness  ☐ Tone/reshape my body  ☐ Decrease body fat  ☐ Improve athletic ability
☐ Increase strength  ☐ Improve flexibility  ☐ Build lean muscle mass  ☐ Decrease stress levels  ☐ Improve mood

Trainer Request ________________________________

Please Print Clearly

Name of Applicant ____________________________________________________________
   (Last)  (First)  (MI)

Date of Birth ________________________________________________________________

Email __________________________________________________________ Phone

Local Address __________________________________________________________ Apt #

City __________________________ State __________________ Zip __________________

Emergency Contact Name __________________________________ Relation to You ____________

Emergency Contact's Phone (primary) ______________________________ Secondary Phone ________________

PARTICIPATION IN ANY ACTIVITY WITHIN THE RECREATION CENTER OR ANY OTHER RECREATION FACILITY IS AT THE SOLE DISCRETION AND JUDGEMENT OF THE MEMBER AND AT HIS OR HER OWN RISK.

I, the undersigned, assume full responsibility for death, injuries, catastrophic injuries or damages which may occur to me in, on, or about the premises of the facility and do hereby fully and forever release and discharge THE UNIVERSITY OF MASSACHUSETTS, the Board of Trustees, employees and representatives from any and all suits, claims, damages, costs and expenses of every kind in conjunction with the use of the Campus Recreation facilities and thereof equipment associated.

I, the undersigned, further agree to use all equipment and activity areas properly and leave them in good condition. I assume total liability and agree to reimburse THE UNIVERSITY OF MASSACHUSETTS for all damages incurred through the misuse of any facility area and/or equipment thereof. I also understand that the Recreation staff is not responsible for any lost, stolen or damaged personal belongings.

I, the undersigned, have received the Personal Training Registration packet, policies and conduct of training sessions and understand there are limitations to my participation as outlined in the packet.

I, the undersigned, certify that the information I have given on this form is complete and accurate.

Applicant's Signature __________________________________________ Date __________________

RECREATION STAFF USE ONLY

Membership Classification: ☐ Faculty/Staff  ☐ Graduate Student  ☐ Continuing Ed  ☐ Retiree  ☐ Associate  ☐ Alumni  ☐ Undergrad  ☐ Community

Package Purchased:  ☐ 2 Sessions  ☐ 4 Sessions  ☐ 6 Sessions  ☐ 10 Sessions  ☐ Fitness Assessment  ☐ Body Composition

Fee Amount $__________________ Method of Payment  ☐ Cash  ☐ Check #__________  ☐ Credit Card Auth. # ____________

CSI Invoice #__________________ Date of Purchase __________________________

Expiration Date of Package ___________________________ Staff Name ____________________ (Please Print Clearly)
Physical Activity Readiness Questionnaire (PAR-Q) and You

(A Questionnaire for People Aged 15-69)

Regular physical activity is fun and healthy, and increasingly more people are starting to become more active every day. Being more active is very safe for most people. However, some people should check with their doctor before they start becoming much more physically active.

If you are planning to become much more physically active than you are now, start by answering the seven questions below. If you are between the ages of 15 and 69, the PAR-Q will tell you if you should check with your doctor before you start. If you are over 69 years of age, and you are not used to being very active, check with your doctor.

Common sense is your best guide when you answer these questions. Please read the questions carefully and answer each one honestly. Check YES or NO.

YES  NO
☐  ☐  1. Has a doctor ever said that you have a heart condition and that you should conduct physical activity with a doctor’s approval?
☐  ☐  2. Do you feel pain in your chest when you do physical activity?
☐  ☐  3. In the past month, have you had chest pain when you were not doing physical activity?
☐  ☐  4. Do you lose your balance because of dizziness or do you ever lose consciousness?
☐  ☐  5. Do you have a bone or joint problem that could be worsened by a change in your physical activity?
☐  ☐  6. Is your doctor currently prescribing drugs (for example, water pills) for your blood pressure or heart condition?
☐  ☐  7. Do you know of any other reason why you should not do physical activity?

If you answered YES to one or more questions

YOUR DOCTOR MUST COMPLETE THE MEDICAL RELEASE FORM BEFORE YOU BEGIN AN EXERCISE PROGRAM!

Talk with your doctor by phone or in person BEFORE you start becoming much more physically active or BEFORE you have a fitness appraisal. Tell your doctor about the PAR-Q and which questions you answered YES.

- You may be able to do any activity you want – as long as you start slowly and build up gradually. Or, you may need to restrict your activities to those which are safe for you. Talk with your doctor about the kinds of activities you wish to participate in and follow his/her advice.
- Find out which community programs are safe and helpful for you.

DELAY BECOMING MUCH MORE ACTIVE:
- If you are not feeling well because of a temporary illness such as a cold or a fever – wait until you feel better; or
- If you are or may be pregnant – talk to your doctor before you start becoming more active.

PLEASE NOTE: If your health changes so that you then answer YES to any of the above questions, tell your fitness or health professional. Ask whether you should change your physical activity plan.

If you answered NO honestly to all the questions

If you answered NO to all PAR-Q questions, you can be reasonably sure that you can:
- Start becoming much more physically active – begin slowly and build up gradually. This is the safest and easiest way to go.
- Take part in a fitness assessment – this is an excellent way to determine your basic fitness level so that you can better plan a healthy lifestyle. It is also highly recommended that you have your blood pressure evaluated. If your reading is over 144/94, talk with your doctor before you start becoming much more physically active.

I have read, understood and completed this questionnaire. Any questions I had were answered to my full satisfaction.

NAME______________________________________________ DATE_________________________

SIGNATURE_________________________________________ WITNESS____________________________

Note: This physical activity clearance is valid for a maximum of 12 months from the date it is completed and becomes invalid if your condition changes so that you would answer YES to any of the seven questions.

Informed use of the PAR-Q: Reprinted from ACSM’s Health/Fitness Facility Standards and Guidelines, 1997 by American College of Sports Medicine
HEALTH HISTORY QUESTIONNAIRE

Information you provide is personal and confidential. The information will enable us to better understand you and your health and fitness habits, as well as inform you of any potential risks. Please consult your physician before beginning any type of exercise program.

NAME ___________________________________________ ID ___________________________ DATE ______/______/_______

Physician’s Name ___________________________________________ Phone __________________ Fax __________________________

GENERAL

Height ______ ft Weight ______ lbs

Any unexplained significant weight loss/gain

Within the last 6 months □ Within the last year □ NO □

If yes, please explain________________________________________________________________________________________

What was your most recent blood pressure reading? ________/_______ mm hg date____________________

Do you currently exercise? YES □ NO □

If yes, how long have you been exercising regularly? ________________________________________________________________

What exercise do you do and how often? ____________________________

________________________________________________________________________

MEDICAL DIAGNOSES

Please list any past or present medical diagnoses or concerns:

________________________________________________________________________________________

________________________________________________________________________________________

________________________________________________________________________________________

________________________________________________________________________________________

________________________________________________________________________________________

________________________________________________________________________________________

Please list any injuries or limitations from the past year:

________________________________________________________________________________________

________________________________________________________________________________________

________________________________________________________________________________________

________________________________________________________________________________________

________________________________________________________________________________________

________________________________________________________________________________________

Please list all known allergies:

________________________________________________________________________________________

________________________________________________________________________________________

________________________________________________________________________________________

________________________________________________________________________________________

________________________________________________________________________________________

________________________________________________________________________________________

Any special conditions not listed above:

________________________________________________________________________________________

________________________________________________________________________________________

________________________________________________________________________________________

________________________________________________________________________________________

________________________________________________________________________________________

It is RECOMMENDED that you consult with your physician before beginning your exercise program if you have any medical conditions or concerns.

MEDICATIONS

Please list any medications you are currently taking including but not limited to prescriptions, allergy medications, ergogenic aids, diet supplements, vitamins, minerals, etc.

________________________________________________________________________________________

________________________________________________________________________________________

________________________________________________________________________________________

________________________________________________________________________________________

________________________________________________________________________________________

________________________________________________________________________________________

________________________________________________________________________________________

________________________________________________________________________________________

________________________________________________________________________________________

________________________________________________________________________________________
**MAJOR RISK FACTORS**

1. Are you a man over the age of 45 or a woman over the age of 55 who has had a hysterectomy or is postmenopausal?  
   - YES □ NO □ UNSURE □

2. Has your father or brother experienced a heart attack before age 55?  
   Or has your mother or sister experienced a heart attack before the age of 65?  
   Who? __________________________
   - YES □ NO □ UNSURE □

3. Has your doctor ever told you that you might have high blood pressure?  
   - YES □ NO □ UNSURE □

4. Do you have cholesterol above 200 ml/dl?  
   Total cholesterol __________ HDL ____________ Date tested ___________ Unknown ____________
   - YES □ NO □ UNSURE □

5. Do you have impaired fasting glucose (diabetes)?  
   If yes, do you take insulin? YES □ NO □  What year were you diagnosed? _________
   - YES □ NO □ UNSURE □

6. Are you physically inactive (i.e. you get less than 30 minutes of physical activity on at least 3 days per week)?  
   - YES □ NO □ UNSURE □

7. Do you currently smoke or have you quit smoking in the last 6 months?  
   I smoke (#) _______cigarettes per day/week (circle one) for _______years  
   I smoked (#) _______cigarettes per day/week (circle one) _______years ago.  
   - YES □ NO □ UNSURE □

8. Are you > 20 pounds overweight?  
   - YES □ NO □ UNSURE □

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**If you are a man over the age of 45 or a woman over the age of 55 OR if you answered “YES” to two (2) or more of the above major risk factors, your physician MUST complete the Medical Release Form at the back of this packet prior to beginning your training package.**

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**MAJOR SIGNS/SYMPTOMS SUGGESTIVE OF CARDIOVASCULAR AND PULMONARY DISEASE**

1. Pain or discomfort (or anginal equivalent) in the chest, neck, jaw, arms, or other areas that may be due to ischemia (decreased blood flow)  
   - YES □ NO □ UNSURE □

2. Shortness of breath at rest or w/mild exertion  
   - YES □ NO □ UNSURE □

3. Dizziness or syncope at rest or w/mild exertion  
   - YES □ NO □ UNSURE □

4. Orthopnea/paroxysmal nocturnal dyspnea (shortness of breath) at rest or w/mild exertion  
   - YES □ NO □ UNSURE □

5. Edema (excessive accumulation of tissue fluid)  
   - YES □ NO □ UNSURE □

6. Palpitations or tachycardia (sudden rapid heart beat)  
   - YES □ NO □ UNSURE □

7. Intermittent claudication (lameness due to decreased blood flow)  
   - YES □ NO □ UNSURE □

8. Known heart murmur (abnormal heart sound)  
   - YES □ NO □ UNSURE □

9. Unusual fatigue or shortness of breath with usual activities  
   - YES □ NO □ UNSURE □

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**If you answered, “YES” to any of the above major signs and symptoms listed above OR have known cardiovascular, pulmonary or metabolic disease (see below for descriptions), it is STRONGLY RECOMMENDED that you seek physician's clearance before beginning your exercise program.**

Cardiovascular – cardiac, peripheral vascular, cerebro-vascular disease  
Pulmonary – chronic obstructive pulmonary disease, asthma, interstitial lung disease, or cystic fibrosis  
Metabolic Disease – diabetes mellitus (types 1 and 2), thyroid disorders, renal or liver disease

I understand this Health History Questionnaire has been provided to me for the purpose of helping me better understand any potential risks associated with a workout program. I also understand I should share this information with my physician and seek his or her approval prior to beginning an exercise program. I understand the information I have provided will be maintained in my membership file for use in case of a medical emergency. My signature signifies that all of the above is true, to the best of my knowledge. Any information left unanswered was done so intentionally. If any of the above information changes, I agree to submit these changes in writing to the Assistant Director for Fitness/Wellness for an update to my membership file.

Signature ___________________________________ Date __________________ Received by __________________ Date __________________

Note: All major factors, signs and symptoms classifications are taken directly from American College of Sports Medicine (ACSM) Guidelines for Exercise Testing and Prescription (Mitchell H. Whaley, ed. © 2006)
EXERCISE HISTORY AND GOALS

Name_______________________________________________ Date___________________

1. On a scale of 1 to 5 (5 indicating very strenuous), please rate your level of perceived exertion while exercising for each age range (through your present age):
   15-20______ 21-30______ 31-40______ 41-50______ 51+______

2. Do you have any prior experience with fitness, sports, or exercise?  
   □ Yes  □ No  If yes, please specify__________________________

3. Are you currently involved in regular exercise?  Yes/No  
   If yes, please specify type(s) of exercise ___________________________  
   _______ Minutes/Day  _______Days/Week

4. How long have you been exercising regularly?  
   _______months  _______years  or  _______N/A

5. Do you start exercise programs but then find yourself unable to stick with them?  
   □ Yes  □ No

6. What types of exercise interest you?
   □ walking  □ jogging  □ group fitness
   □ cycling  □ aerobics  □ strength training
   □ stationary bike  □ running  □ team sports
   □ hiking  □ swimming  □ yoga / Pilates
7. Rank your goals in undertaking exercise. Use the following scale to rate each goal separately:

<table>
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<th>not important</th>
<th>somewhat important</th>
<th>extremely important</th>
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<td>7  8</td>
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<td>9</td>
<td>10</td>
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a. Improve cardiovascular fitness ______
b. Body-fat weight loss ______
c. Reshape or tone my body ______
d. Improve performance for a specific sport ______
e. Improve moods and ability to cope with stress ______
f. Improve flexibility ______
g. Increase strength ______
h. Increase energy level ______
i. Feel better ______
j. For enjoyment ______
k. Other ______

8. Please describe your personal fitness goals:
___________________________________________________________________________________________________
___________________________________________________________________________________________________
___________________________________________________________________________________________________

9. What is your time frame for accomplishing these goals? ______________________________
This agreement ensures that the relationship between the client and personal trainer is clearly appreciated, respected and understood. This agreement must be signed prior to beginning training.

**Client Responsibilities**

1. Personal training fees must be paid in full prior to scheduling the first session.

2. The client’s personal training packet must be completed at the time of purchase. Failure to do so may result in delayed initial consultation. All forms will be confidential to the client and assigned personal trainer.

3. This personal training packet entitles the client to one hour long (60 minute) training session(s), which will include exercise counseling and assessment.

4. If the client is late, the session will only last until the end of the hour that the session was scheduled. A courtesy phone call to the trainer is appreciated.

5. **Eat something before your session, so that your body will have energy. Do NOT eat a major meal within 3 hours prior to your session (small snacks are ideal).**

6. Arrive (at least) 5 minutes prior to the scheduled session to complete prepare. Please be prompt to ensure a complete workout.

7. **Cancellations must occur within 24 hours prior to your scheduled session.** Failure to do so will result in the client forfeiting the session and no payment reimbursement will be granted.

8. Clients must abide by Campus Recreation facility policies and guidelines. Be advised that policies may change, in which case your personal trainer will inform you.

9. It is recommended that you bring water to each session.

10. If you have any questions, please contact the Assistant Director for Fitness/Wellness at (413) 577-0855.

**Personal Trainer Responsibilities**

1. Personal trainers provide Campus Recreation members with the motivation, education, guidance and individual instruction necessary to achieve their personal fitness goals.

2. Trainers will design a safe, effective exercise program that reflects the client’s objectives, fitness level and experience.

3. If the trainer is late, the client may decide to (a) reschedule the session (b) continue with the scheduled session, and the time owed is allotted to that client at no additional charge.

4. Once a personal training package/session is purchased and all forms have been completed and submitted, the Assistant Director for Fitness/Wellness will review the forms. If the participant is approved for personal training, the assigned personal trainer will contact the client within 2-3 business days.

5. The personal trainer will allow for an open line of communication throughout the course of the client/trainer relationship.

6. If you feel a personal trainer or other fitness staff does not provide a sufficient level of customer service, please contact the Assistant Director for Fitness/Wellness at (413) 577-0855.

Client Signature __________________________ Date __________________________
Dear Dr. __________________________,

Your patient __________________________ is interested in taking part in the University of Massachusetts Amherst Campus Recreation Personal Training Program. The pre-screening process will involve testing of body composition, cardiovascular endurance, muscular endurance, muscular strength, and flexibility. All assessments will be administered by a certified personal trainer, qualified in assessment techniques, First Aid, CPR and AED.

Your patient has completed a physical activity readiness questionnaire and has demonstrated concern for medical clearance. By completing this form you are signifying that there are no medical reasons which preclude your patient from participating in the University of Massachusetts Amherst Campus Recreation Personal Training Program.

Please complete the following:

Please identify any recommendations or restrictions that are appropriate for your patient in this exercise program:
________________________________________________________________________
________________________________________________________________________
________________________________________________________________________

If your patient is taking medications that will affect his or her exercise capacity or heart-rate response to exercise, please indicate the manner of the effect (raises, lowers, or has no effect on exercise capacity or heart-rate response)
________________________________________________________________________
________________________________________________________________________
________________________________________________________________________

Please identify any recommendations or restrictions that are appropriate for your patient in this exercise program:
________________________________________________________________________
________________________________________________________________________
________________________________________________________________________

_____ The applicant has my approval to begin an exercise program with the recommendations or restrictions stated above.

_____ I would NOT RECOMMEND that the applicant participate in an exercise program at this time.

Physician’s Signature __________________________ Date ____________ Phone ____________________

Client’s Printed Name __________________________

Thank you for taking the time to complete this form.